APPLICATION FOR INDIANA WHOLESALE DRUG DISTRIBUTOR LICENSE

State Form 47228 (R2 / 7-02)

Approved by State Board of Accounts, 2002

Health Professions Bureau
Indiana Board of Pharmacy

FOR OFFICIAL USE ONLY	
Application fee	
Date fee paid	Date application received
Receipt number	C.M.

* The request for Social Security number(s) is **MANDATORY** according to IC 4-1-8-1.

Legal name of business

Full facility address *(number and street, city, state, ZIP code)*

Mailing address of facility *(if different from business name)*

County

Telephone number ( )

Name of contact person

Telephone number ( )

Address of contact person

Email address

Name of person responsible for the operation of the facility

Telephone number ( )

Address of person responsible for the operation of the facility

List all trade or business names used by the corporation or licensee

List name(s) and Social Security number(s) * of the owner(s) and/or operator(s) of the licensee. Indicate the type of ownership. **Partnerships -** give the name of each partner and address of each partnership; **Corporations -** give the name and title of each corporate officer and director, the corporate name(s), name and address of the parent company *(if any)*, and the state of incorporation; **Sole Proprietorships -** give the name of the sole proprietor and the name and address of the business entity. *(attach a separate sheet if more space is needed)*

Type of operation *(check all that apply)*

- ☐ Full Service Wholesaler
- ☐ Retail or Hospital Pharmacy Conducting Wholesale Distribution
- ☐ Distributors' Warehouse
- ☐ Manufacturer
- ☐ Private-label Distributor
- ☐ Contract Distributor
- ☐ Chain Drug Warehouse
- ☐ Repacker
- ☐ Own-label Dristributor
- ☐ Jobber or Broker
- ☐ Independent Wholesale Drug Trader
- ☐ Medical Gas Seller/Distrubutor/Relabeler
- ☐ Manufacturers' Warehouse
- ☐ Other *(specify)*

Sells drugs to: *(check all that apply)*

- ☐ Community Pharmacies
- ☐ Veterinarians
- ☐ Physicians or Other Practitioners
- ☐ Hospital Pharmacies
- ☐ Wholesalers
- ☐ Other *(specify)*

Types of drugs distributed *(check all that apply)*

- ☐ Controlled Substances
- ☐ Non-prescription Drugs
- ☐ Non-controlled Prescription Drugs
- DEA Number _____
- ☐ Other *(specify)*

List and explain if an answer to any of the questions below is "Yes" by attaching a separate letter explaining the situation(s) in detail.

Have any of the applicant(s) and/or managers had any convictions relating to drug samples, wholesale or retail distribution, or distribution of controlled substances? ☐ Yes ☐ No

Have any of the applicant(s) and/or managers had any felony convictions? ☐ Yes ☐ No

Have any of the applicant(s) and/or managers had a suspension or revocation by the federal or state government of any license held by the applicant(s) for the manufacturer or distribution of any drugs, including controlled substances? ☐ Yes ☐ No

Is any action pending on any of the above? ☐ Yes ☐ No

I do solemnly swear or affirm, under the penalties of perjury, that I am the person authorized to sign this application for licensure and that statements made are true and correct in all respects.

Signature of owner or corporate officer

Date signed *(month, day, year)*

Title of owner or corporate officer

Social Security number